Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
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Original Public Report

Report Issue Date: September 13, 2023
Inspection Number: 2023-1595-0004
Inspection Type: Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Carefree Lodge, North York

Lead Inspector	**Inspector Digital Signature**
Ann McGregor (000704)	Ann Marie Mcgregor Lawrence Digitally signed by Ann Marie Mcgregor Lawrence Date: 2023.09.15 17:20:38 -04'00'

Additional Inspector(s)
Maya Kuzmin (741674)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 6-8, 2023.

The following Critical Incidents (CI) intake(s) were inspected:

- Intake #00086566/CI#M596-000007-23 was related to falls prevention and management.
- Intake #00093049/CI#M596-000010-23 was related to IPAC, ARI outbreak declared.

The following Critical Incident (CI) intake was completed.

- Intake #0021182/M596-000002-23 – was related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked to restrict unsupervised access to those areas by residents, when they were not supervised by staff.

Rationale and Summary:
During an observation, a door leading to a non-residential area was open for a while without any staff supervision.

Inspector notified Acting Building Services Managers (ABSM) that the door was open and they proceeded to close the door.

They acknowledged that the door was unlocked during an observation and stated that staff may have forgotten to close the door. They confirmed that the room housed the nursing supplies and a sink, and that the expectation was to keep the doors to any non-residential areas closed and locked to restrict unsupervised access by residents.

Sources: Observations; interview with ABSM

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Date Remedy Implemented: September 6, 2023

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of their Infection Prevention and Control (IPAC) program.

Rationale and Summary:
The home's policy on the appropriate use of Personal Protective Equipment (PPE), directed staff to apply IPAC practices before and after direct contact with the resident and their environment.

A Personal Support Worker (PSW) was seen going into a resident's room that required IPAC measures. The PSW did not perform the proper IPAC practices prior entering the resident's room. While inside the resident's room, the staff changed the PPE after providing hydration to the resident, and IPAC measures were not performed properly. Upon exiting the resident's room, the staff did not perform the required IPAC measures. A PSW communicated the proper steps that are to be followed during the provision of care for a resident with IPAC measures in place. However, they acknowledged that they did not follow the Long-Term Care Home's policy and procedures related to the IPAC programs.

The IPAC Practitioner confirmed that staff did not follow the Long-Term Care Home's policy in relation to IPAC.

There was a risk of infection transmission when staff did not follow the required PPE practices prior to providing care to the resident.

Sources: Observation; IPAC Policy; and interviews with the PSW and other staff.

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